FOR BHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039115

Facility Name: Wheaton Care Center

Address: 1325 Manchester Road (Number) Wheaton (City) 60187 (Zip Code)

County: Dupage

Telephone Number: (630) 668-2500 **Fax #** (630) 668-0232

HFS ID Number: 363905787001

Date of Initial License for Current Owners: 09/01/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Edward N. Slack, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	82	Skilled (SNF)	82	29,930	1
2		Skilled Pediatric (SNF/PED)			2
3	41	Intermediate (ICF)	41	14,965	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	123	TOTALS	123	44,895	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,932	154	1,064	5,150	8
9	SNF/PED					9
10	ICF	35,391	1,387	90	36,868	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,323	1,541	1,154	42,018	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.59%

D. How many bed-hold days during this year were paid by the Department?
1,022 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 9/1/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 9/1/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [ ] If YES, enter number of beds certified 81 and days of care provided 1,064

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	218,860	28,672	12,816	260,348		260,348	(3,930)	256,418			1
2	Food Purchase		161,998		161,998		161,998	1,943	163,941			2
3	Housekeeping	161,954	25,955		187,909		187,909	(2,324)	185,585			3
4	Laundry	25,364	17,868		43,232		43,232	(46)	43,186			4
5	Heat and Other Utilities			164,313	164,313		164,313	1,682	165,995			5
6	Maintenance	40,422		161,501	201,923		201,923	(2,761)	199,162			6
7	Other (specify):*							1,218	1,218			7
8	**TOTAL General Services**	446,600	234,493	338,630	1,019,723		1,019,723	(4,217)	1,015,506			8
	B. Health Care and Programs											
9	Medical Director			1,100	1,100		1,100		1,100			9
10	Nursing and Medical Records	1,501,422	46,870	28,097	1,576,389		1,576,389	(4,126)	1,572,263			10
10a	Therapy	23,715		24	23,739		23,739	402	24,141			10a
11	Activities	75,707	8,559	3,136	87,402		87,402		87,402			11
12	Social Services	150,325	699	520	151,544		151,544		151,544			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							856	856			15
16	**TOTAL Health Care and Programs**	1,751,169	56,128	32,877	1,840,174		1,840,174	(2,868)	1,837,306			16
	C. General Administration											
17	Administrative	95,138			95,138		95,138	25,077	120,215			17
18	Directors Fees											18
19	Professional Services			284,375	284,375		284,375	(213,052)	71,323			19
20	Dues, Fees, Subscriptions & Promotions			50,025	50,025		50,025	(11,438)	38,587			20
21	Clerical & General Office Expenses	83,996	13,873	145,049	242,918		242,918	32,807	275,725			21
22	Employee Benefits & Payroll Taxes			326,813	326,813		326,813	(3,742)	323,071			22
23	Inservice Training & Education			297	297		297		297			23
24	Travel and Seminar			2,367	2,367		2,367	3,559	5,926			24
25	Other Admin. Staff Transportation			3,973	3,973		3,973		3,973			25
26	Insurance-Prop.Liab.Malpractice			131,337	131,337		131,337	1,297	132,634			26
27	Other (specify):*							23,849	23,849			27
28	**TOTAL General Administration**	179,134	13,873	944,236	1,137,243		1,137,243	(141,643)	995,600			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,376,903	304,494	1,315,743	3,997,140		3,997,140	(148,728)	3,848,412			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Wheaton Care Center #0039115 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			82,933	82,933		82,933	97,625	180,558			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,500	3,500		3,500	(3,500)				32
33	Real Estate Taxes			56,116	56,116		56,116	1,383	57,499			33
34	Rent-Facility & Grounds			661,440	661,440		661,440	(213,448)	447,992			34
35	Rent-Equipment & Vehicles			1,901	1,901		1,901	1,185	3,086			35
36	Other (specify):*			2,245	2,245		2,245		2,245			36
37	**TOTAL Ownership**			808,135	808,135		808,135	(116,755)	691,380			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		79,365	36,274	115,639		115,639	(2,869)	112,770			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,345	67,345		67,345		67,345			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		79,365	103,619	182,984		182,984	(2,869)	180,115			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,376,903	383,859	2,227,497	4,988,259		4,988,259	(268,351)	4,719,908			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,204	30		9
10	Interest and Other Investment Income	(82,732)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(59)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,079)	21		18
19	Entertainment				19
20	Contributions	(315)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(36,000)	21		24
25	Fund Raising, Advertising and Promotional	(14,259)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(46)	20		28
29	Other-Attach Schedule	(130,387)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (259,673)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(8,678)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (8,678)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (268,351)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 5A

Wheaton Care Center

ID# 003911 5

Report Period Beginning: 01/01/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Clothing	$ (110)	10	1
2	Theft Loss	(44)	21	2
3	Collection Expense	(4,288)	21	3
4	Cope Dues	(431)	20	4
5	Prior Year legal Fees	(37,190)	19	5
6	Non-Allowable Billing Consulting	(16,279)	19	6
7	Capitalized R & M	(10,586)	06	7
8	Non-Allowable Expense	(60,000)	21	8
9	Misc. Admin Expenses - Bldg. Comp.	(358)	21	9
10	Bank Charges- Bldg. Comp.	(26)	21	10
11	Misc. Expense	(1,075)	21	11
12				12
13				13
14				14
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98				98
99				99
100				100
101	**Total**	(130,387)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Wheaton Care Center **#** 0039115 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary					267		(1,441)	(2,756)				(3,930)	1
2	Food Purchase	(59)							2,002				1,943	2
3	Housekeeping				(2,324)								(2,324)	3
4	Laundry				(46)								(46)	4
5	Heat and Other Utilities					1,682							1,682	5
6	Maintenance	(10,586)			(4)	4,112		3,709	8				(2,761)	6
7	Other (specify):*						123	971	124				1,218	7
8	**TOTAL General Services**	(10,645)			(2,373)	6,061	123	3,239	(622)				(4,217)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(110)			(4,016)								(4,126)	10
10a	Therapy							402					402	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*						801	55					856	15
16	**TOTAL Health Care and Programs**	(110)			(4,016)		801	457					(2,868)	16
	C. General Administration													
17	Administrative					2,757		22,260	60				25,077	17
18	Directors Fees													18
19	Professional Services	(53,469)				(159,584)			1				(213,052)	19
20	Fees, Subscriptions & Promotions	(15,051)			(5)	3,616			2				(11,438)	20
21	Clerical & General Office Expenses	(102,870)	384			13,441		121,714	138				32,807	21
22	Employee Benefits & Payroll Taxes						(3,742)						(3,742)	22
23	Inservice Training & Education													23
24	Travel and Seminar					3,511			48				3,559	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice					1,254			43				1,297	26
27	Other (specify):*						3,193	20,656					23,849	27
28	**TOTAL General Administration**	(171,390)	384		(5)	(135,005)	(549)	164,630	292				(141,643)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(182,145)	384		(6,393)	(128,944)	375	168,326	(330)				(148,728)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Wheaton Care Center** **#** **0039115** **Report Period Beginning:** **01/01/05** **Ending:** **12/31/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	**5 & 5A**	**6**	**6A**	**6B**	**6C**	**6D**	**6E**	**6F**	**6G**	**6H**	**6I**	**(to Sch V, col.7)**	
30	Depreciation	**5,204**	**74,082**			**17,527**			**23**	**789**			**97,625**	**30**
31	Amortization of Pre-Op. & Org.													**31**
32	Interest	**(82,732)**	**75,950**			**2,926**			**77**	**279**			**(3,500)**	**32**
33	Real Estate Taxes					**1,383**							**1,383**	**33**
34	Rent-Facility & Grounds		**(220,000)**			**6,552**							**(213,448)**	**34**
35	Rent-Equipment & Vehicles					**1,181**			**4**				**1,185**	**35**
36	Other (specify):*													**36**
37	**TOTAL Ownership**	**(77,528)**	**(69,968)**			**29,569**			**104**	**1,068**			**(116,755)**	**37**
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													**38**
39	Ancillary Service Centers				**(68)**				**(431)**	**(2,370)**			**(2,869)**	**39**
40	Barber and Beauty Shops													**40**
41	Coffee and Gift Shops													**41**
42	Provider Participation Fee													**42**
43	Other (specify):*													**43**
44	**TOTAL Special Cost Centers**				**(68)**				**(431)**	**(2,370)**			**(2,869)**	**44**
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**(259,673)**	**(69,584)**		**(6,461)**	**(99,375)**	**375**	**168,326**	**(657)**	**(1,302)**			**(268,351)**	**45**

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached			See Attached	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 220,000	Wheaton HC Properties	100.00%	$	$ (220,000)	1
2	V	21	Misc. Admin. Expenses		Wheaton HC Properties	100.00%	358	358	2
3	V	21	Bank Charges		Wheaton HC Properties	100.00%	26	26	3
4	V	30	Depreciation		Wheaton HC Properties	100.00%	74,082	74,082	4
5	V	32	Interest - CIB Bank		Wheaton HC Properties	100.00%	32,654	32,654	5
6	V	32	Interest - Wheaton Convalescent		Wheaton HC Properties	100.00%	7,500	7,500	6
7	V	32	Interest - Manchester Manor		Wheaton HC Properties	100.00%	35,796	35,796	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 220,000			$ 150,416	$ * (69,584)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INSURANCE	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 107,761	$ 107,761	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	107,761	CCS EMPLOYEE BENEFIT GROUP	100.00%		(107,761)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 107,761			$ 107,761	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETARY	$	XCEL MEDICAL SUPPLY, LLC	100.00%	$	$	15
16	V	02	FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%			16
17	V	03	HOUSEKEEPING	23,438	XCEL MEDICAL SUPPLY, LLC	100.00%	21,114	(2,324)	17
18	V	04	LAUNDRY	459	XCEL MEDICAL SUPPLY, LLC	100.00%	414	(46)	18
19	V	06	REPAIRS & MAINTENANCE	38	XCEL MEDICAL SUPPLY, LLC	100.00%	34	(4)	19
20	V	10	NURSING	40,505	XCEL MEDICAL SUPPLY, LLC	100.00%	36,489	(4,016)	20
21	V	11	ACTIVITIES		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V	20	DUES, FEES, SUBSCRIPTIONS & PROM	48	XCEL MEDICAL SUPPLY, LLC	100.00%	43	(5)	22
23	V	21	CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%			23
24	V	22	EMPLOYEE BENEFITS		XCEL MEDICAL SUPPLY, LLC	100.00%			24
25	V	39	ANCILLARY	682	XCEL MEDICAL SUPPLY, LLC	100.00%	614	(68)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 65,170			$ 58,709	$ * (6,461)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Care Centers, Inc.	100.00%	$ 267	$ 267	15
16	V	05	Utilities		Care Centers, Inc.	100.00%	1,682	1,682	16
17	V	06	Maintenance		Care Centers, Inc.	100.00%	4,112	4,112	17
18	V				Care Centers, Inc.	100.00%			18
19	V	17	Administration		Care Centers, Inc.	100.00%	2,757	2,757	19
20	V	19	Professional Fees	175,024	Care Centers, Inc.	100.00%	15,440	(159,584)	20
21	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	3,616	3,616	21
22	V	21	Office & Clerical		Care Centers, Inc.	100.00%	13,441	13,441	22
23	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	3,511	3,511	23
24	V	26	Insurance		Care Centers, Inc.	100.00%	1,254	1,254	24
25	V	30	Depreciation		Care Centers, Inc.	100.00%	17,527	17,527	25
26	V	32	Interest		Care Centers, Inc.	100.00%	2,926	2,926	26
27	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	1,383	1,383	27
28	V	34	Rent - Building		Care Centers, Inc.	100.00%	6,552	6,552	28
29	V	35	Rent - Equipment and Auto		Care Centers, Inc.	100.00%	1,181	1,181	29
30	V	25	Bus Reimbursement		Care Centers, Inc.	100.00%			30
31	V	02	Food		Care Centers, Inc.	100.00%			31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 175,024			$ 75,649	$ * (99,375)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance Salary	$ 857	Care Centers, Inc.	100.00%	$ 857	$	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	123	123	16
17	V	10	Nursing Salary	4,985	Care Centers, Inc.	100.00%	4,985		17
18	V	10a	Rehab Salary		Care Centers, Inc.	100.00%			18
19	V								19
20	V								20
21	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	801	801	21
22	V	17	Administration Salary		Care Centers, Inc.	100.00%			22
23	V	21	Office Salary	19,417	Care Centers, Inc.	100.00%	19,417		23
24	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	3,193	3,193	24
25	V	22	Employee Benefits	3,742	Care Centers, Inc.	100.00%		(3,742)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 29,001			$ 29,376	$ * 375	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		01	Dietary Salary	$ 4,490	Care Centers, Inc.	100.00%	$ 3,049	$ (1,441)	15
16	V									16
17	V		06	Maintenance Salary		Care Centers, Inc.	100.00%	3,709	3,709	17
18	V		07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	971	971	18
19	V									19
20	V		10a	Rehab Salary		Care Centers, Inc.	100.00%	402	402	20
21	V		15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	55	55	21
22	V									22
23	V		17	Administration Salary		Care Centers, Inc.	100.00%	22,260	22,260	23
24	V		21	Office Salary		Care Centers, Inc.	100.00%	121,714	121,714	24
25	V		27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	20,656	20,656	25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 4,490			$ 172,816	$ * 168,326	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 3,806	Care Centers, Inc. - Health Systems Division	100.00%	$ 234	$ (3,572)	15
16	V	02	Food		Care Centers, Inc. - Health Systems Division	100.00%	2,002	2,002	16
17	V	06	Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	8	8	17
18	V	17	Administration		Care Centers, Inc. - Health Systems Division	100.00%	60	60	18
19	V	19	Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	1	1	19
20	V	20	Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	2	2	20
21	V	21	Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	138	138	21
22	V	24	Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	48	48	22
23	V	26	Insurance		Care Centers, Inc. - Health Systems Division	100.00%	43	43	23
24	V	30	Depreciaton		Care Centers, Inc. - Health Systems Division	100.00%	23	23	24
25	V	32	Interest		Care Centers, Inc. - Health Systems Division	100.00%	77	77	25
26	V	35	Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	4	4	26
27	V	39	Ancillary Enteral Supplies	910	Care Centers, Inc. - Health Systems Division	100.00%	479	(431)	27
28	V	01	Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	816	816	28
29	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	124	124	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 4,716			$ 4,059	$ * (657)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Vent Lease, LLC.	100.00%	$ 789	$ 789	15
16	V	32	Interest		Vent Lease, LLC.	100.00%	279	279	16
17	V	39	Vent Reimbursement	2,370	Vent Lease, LLC.	100.00%		(2,370)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,370			$ 1,068	$ * (1,302)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	21.95%	See Attached	0.90	1.95%	Alloc. Salary	$ 2,172	17-3	1
2	Adam Vales	Relative	Clerical		See Attached	0.71	1.78%	Alloc. Salary	878	22-7	2
3	Mark Steinberg	Relative	Administrative		See Attached	1.56	2.84%	Alloc. Salary	2,091	17-7	3
4	Kim Rudolph	Relative	Clerical		See Attached	0.68	1.94%	Alloc. Salary	969	22-7	4
5	Gale Rothner	Relative	Administrative		See Attached	0.99	2.83%	Alloc. Salary	2,217	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 8,327		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURAI	DIRECT ALLOCATION			$	$		$ 107,761	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 107,761	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY, LLC
Street Address: 2201 W. MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation			$	$		$	1
2	02	FOOD	Direct Allocation							2
3	03	HOUSEKEEPING	Direct Allocation						21,114	3
4	04	LAUNDRY	Direct Allocation						414	4
5	06	REPAIRS & MAINTENANCE	Direct Allocation						34	5
6	10	NURSING	Direct Allocation						36,489	6
7	11	ACTIVITIES	Direct Allocation							7
8	20	DUES, FEES, SUBSCRIPTIONS	Direct Allocation						43	8
9	21	CLERICAL & GENERAL OFFIC	Direct Allocation							9
10	22	EMPLOYEE BENEFITS	Direct Allocation							10
11	39	ANCILLARY	Direct Allocation						614	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 58,709	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,497,287	32	$ 9,406	$	42,562	$ 267	1
2	05	Utilities	Patient Days	1,497,287	32	59,188		42,562	1,682	2
3	06	Maintenance	Patient Days	1,497,287	32	144,661		42,562	4,112	3
4										4
5	17	Administration	Patient Days	1,497,287	32	97,000		42,562	2,757	5
6	19	Professional Fees	Patient Days	1,497,287	32	543,148		42,562	15,440	6
7	20	Dues and Subscriptions	Patient Days	1,497,287	32	127,217		42,562	3,616	7
8	21	Office & Clerical	Patient Days	1,497,287	32	472,845		42,562	13,441	8
9	24	Travel and Seminar	Patient Days	1,497,287	32	123,511		42,562	3,511	9
10	26	Insurance	Patient Days	1,497,287	32	44,126		42,562	1,254	10
11	30	Depreciation	Patient Days	1,497,287	32	616,575		42,562	17,527	11
12	32	Interest	Patient Days	1,497,287	32	102,930		42,562	2,926	12
13	33	Real Estate Taxes	Patient Days	1,497,287	32	48,662		42,562	1,383	13
14	34	Rent - Building	Patient Days	1,497,287	32	230,488		42,562	6,552	14
15	35	Rent - Equipment & Auto	Patient Days	1,497,287	32	41,530		42,562	1,181	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,661,288	$		$ 75,649	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance Salary	Direct Cost			301,710	301,710		857	1
2	07	Emp. Ben. - Gen. Serv.	Direct Cost			46,639			123	2
3	10	Nursing Salary	Direct Cost			425,833	425,833		4,985	3
4	10a	Rehab Salary	Direct Cost			55,464	55,464			4
5										5
6										6
7	15	Emp. Ben. - Healthcare	Direct Cost			67,757			801	7
8	17	Administration Salary	Direct Cost			5,566	5,566			8
9	21	Office Salary	Direct Cost			419,879	419,879		19,417	9
10	27	Emp. Ben. - Gen. Admin.	Direct Cost			71,906			3,193	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,394,755	$ 1,208,453		$ 29,376	25

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Patient Days	1,497,287	32	107,276	107,276	42,562	3,049	1
2										2
3	06	Maintenance Salary	Patient Days	1,497,287	32	130,484	130,484	42,562	3,709	3
4	07	Emp. Ben. - Gen. Serv.	Patient Days	1,497,287	32	34,158		42,562	971	4
5										5
6	10a	Rehab Salary	Patient Days	1,497,287	32	14,139	14,139	42,562	402	6
7	15	Emp. Ben. - Healthcare	Patient Days	1,497,287	32	1,933		42,562	55	7
8					32					8
9	17	Administration Salary	Patient Days	1,497,287	32	783,083	783,083	42,562	22,260	9
10	21	Office Salary	Patient Days	1,497,287	32	4,281,771	4,281,771	42,562	121,714	10
11	27	Emp. Ben. - Gen. Admin.	Patient Days	1,497,287	32	726,674		42,562	20,656	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 6,079,517	$ 5,316,753		$ 172,816	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	928,452		46,000		4,717	234	1
2	02	Food	Income			160,931			2,002	2
3	06	Maintenance	Billable Income	928,452		1,614		4,717	8	3
4	17	Administration	Billable Income	928,452		11,797		4,717	60	4
5	19	Professional Fees	Billable Income	928,452		262		4,717	1	5
6	20	Dues & Subscriptions	Billable Income	928,452		342		4,717	2	6
7	21	Office & Clerical	Billable Income	928,452		27,087		4,717	138	7
8	24	Travel & Seminar	Billable Income	928,452		9,381		4,717	48	8
9	26	Insurance	Billable Income	928,452		8,379		4,717	43	9
10	30	Depreciaton	Billable Income	928,452		4,499		4,717	23	10
11	32	Interest	Billable Income	928,452		15,077		4,717	77	11
12	35	Rent - Equipment & Auto	Billable Income	928,452		843		4,717	4	12
13	39	Ancillary Enteral Supplies	Income			327,517			479	13
14	01	Dietary - Salary	Billable Income	928,452		160,568	160,568	4,717	816	14
15	07	Emp. Ben. - Gen. Serv.	Billable Income	928,452		24,382		4,717	124	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 798,679	$ 160,568		$ 4,059	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Vent Lease, LLC
Street Address: 2201 W. Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	Depreciation	Direct Billing	593,410	29	$ 197,493	$	2,370	$ 789	1
2	32	Interest	Direct Billing	593,410	29	69,863		2,370	279	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 267,356	$		$ 1,068	25

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	CIB		X	Mortgage			$	$ 1,793,654			$ 32,654	1
2	Premier Bank		X	Vehicle				1,635				2
3	First Bank		X	Capital Improvement							3,500	3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Manchester Manor		X	Loan				1,553,929			35,796	6
7	Wheaton Convalescent	X		Loan				500,000			7,500	7
8	See Supplemental Schedule										3,282	8
9	TOTAL Facility Related						$	$ 3,849,218			$ 82,732	9
	B. Non-Facility Related*											
10	Interest Income										(82,732)	10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (82,732)	14
15	TOTALS (line 9+line14)						$	$ 3,849,218			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Alloc from Care Centers		X				$	$			$ 3,003	8
9	Alloc from Vent Lease		X								279	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										3,282	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Wheaton Care Center # 0039115 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 53,153	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 54,685	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,532	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 55,967	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 57,499	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	50,704	8
	2001	49,393	9
	2002	50,559	10
	2003	50,622	11
	2004	53,302	12

2005 Accrual = $53,302 x 1.05 = $55,967

Care Centers Allocation $1,383

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wheaton Care Center COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0039115

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-17-114-010	Long Term Care Property	$ 53,301.92	$ 53,301.92
2.	See Attached	Home Office Allocation	$ 113,458.70	$ 1,383.28
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 166,760.62	$ 54,685.20

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Wheaton Care Center COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0039115

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,000 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2005	$ 828,181	1
2	2201 Main LLC - Allocation		2002	9,997	2
3	TOTALS			$ 838,178	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	41,331		20	2,067	2,067	25,528	9
10	Various			1994	104,965		20	5,250	5,250	61,293	10
11	Various			1995	16,968		20	849	849	9,138	11
12	Various			1996	158,287		20	7,915	7,915	75,354	12
13	Various			1997	103,690		20	5,187	5,187	44,525	13
14	Various			1998	56,873		20	2,846	2,846	20,971	14
15	Various			1999	21,286		20	1,066	1,066	6,958	15
16	Various			2000	57,068		20	2,946	2,946	18,965	16
17	Various			2001	48,282		20	2,534	2,534	12,276	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		1,548,078	40,955		40,955		40,955	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		39,236	1,608		1,608		4,846	68
69	Financial Statement Depreciation			82,933			(82,933)		69
70	TOTAL (lines 4 thru 69)		$ 2,196,064	$ 125,496		$ 73,223	$ (52,273)	$ 320,809	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,196,064	$ 125,496		$ 73,223	$ (52,273)	$ 320,809	1
2	Plumbing	2002	3,707		20	371	371	1,483	2
3	Door Systems	2002	2,810		20	281	281	1,124	3
4	Plumbing	2002	921		20	92	92	361	4
5	Paint	2002	628		20	63	63	246	5
6	Cabinets	2002	2,976		20	198	198	761	6
7	Boiler	2002	1,716		20	172	172	643	7
8	Hvac	2002	759		20	76	76	259	8
9	Carpeting	2002	1,526		20	218	218	727	9
10	Boiler	2002	700		20	58	58	190	10
11	Hvac	2003	683		20	68	68	205	11
12	Freezer Relay Switch	2003	517		20	34	34	103	12
13	Repair Emergency Electric System	2003	595		20	30	30	84	13
14	Fire Alarm Repair	2003	522		20	75	75	205	14
15	Elijer Wall Mount Toilet	2003	525		20	26	26	72	15
16	Walk-In Freezer	2003	698		20	35	35	93	16
17	Sprinkler Repair	2003	679		20	97	97	251	17
18	A/C Repair	2003	941		20	78	78	203	18
19	Hvac	2003	2,396		20	479	479	1,198	19
20	Sprinkler System Repair	2003	878		20	44	44	99	20
21	6Ft High Fence	2003	6,126		20	613	613	1,378	21
22	Sprinkler System Repair	2003	2,160		20	309	309	669	22
23	Cement Drain And Pit	2003	1,580		20	158	158	342	23
24	3 New Doors	2004	2,880		20	288	288	576	24
25	Pyro-Chem Kitchen System	2004	1,985		20	199	199	397	25
26	Smoke Detectors	2004	1,059		20	212	212	424	26
27	Repair Boiler	2004	895		20	179	179	358	27
28	Generator Repair	2004	540		20	108	108	216	28
29	Ceiling Radiation Fire Dampers	2004	845		20	169	169	338	29
30	Three Fire Dampers	2004	500		20	50	50	92	30
31	Gutters	2004	4,100		20	410	410	752	31
32	Exhaust System	2004	3,290		20	329	329	603	32
33	Landscaping	2004	14,000		20	933	933	1,400	33
34	TOTAL (lines 1 thru 33)		$ 2,260,201	$ 125,496		$ 79,675	$ (45,821)	$ 336,661	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,260,201	$ 125,496		$ 79,675	$ (45,821)	$ 336,661	1
2	Repair Limestone	2004	2,055		20	206	206	343	2
3	Interior Hand Rail	2004	1,636		20	164	164	273	3
4	Exterior Hand Rail	2004	9,600		20	960	960	1,600	4
5	Keypad	2004	587		20	59	59	98	5
6	Fire Alarm System	2004	43,000		20	4,300	4,300	7,167	6
7	Solenoid Valve	2004	1,180		20	79	79	125	7
8	Diesel Generator	2004	5,667		20	1,133	1,133	1,700	8
9	Cubicle Curtains	2004	589		20	118	118	177	9
10	Wire Mesh	2004	1,750		20	175	175	248	10
11	Sidewalk	2004	1,400		20	93	93	132	11
12	Diesel Generator	2004	5,667		20	1,133	1,133	1,606	12
13	Kitchen Grease Trap	2004	2,200		20	220	220	293	13
14	Generator Project	2004	5,667		20	1,133	1,133	1,511	14
15	Sales Tax On Generator	2004	810		20	162	162	216	15
16	Sign	2004	775		20	155	155	207	16
17	Electric Generator	2004	5,921		20	592	592	789	17
18	Plumbing Repair	2004	2,201		20	220	220	275	18
19	Repair Cooler In Kitchen	2004	1,025		20	205	205	256	19
20	Installation Of Generator	2004	5,146		20	515	515	557	20
21	Sprinkler System Service	2004	615		20	62	62	67	21
22	Sprinkler Repair	2004	2,100		20	210	210	228	22
23	Sprinkler Repair	2004	2,500		20	250	250	271	23
24	Generator Service	2004	762		20	152	152	165	24
25	Paint	2004	553		20	28	28	51	25
26	Paint	2004	564		20	28	28	38	26
27	Payment On Generator	2005	5,146		20	515	515	515	27
28	New Fire Alarm System	2005	3,000		20	300	300	300	28
29	New Fire Alarm System	2005	3,000		20	300	300	300	29
30	New Fire Alarm System	2005	3,000		20	300	300	300	30
31	New Fire Alarm System	2005	3,000		20	300	300	300	31
32	Hvac Modification	2005	7,400		20	678	678	678	32
33	Abatement	2005	2,950		20	25	25	25	33
34	TOTAL (lines 1 thru 33)		$ 2,391,667	$ 125,496		$ 94,445	$ (31,051)	$ 357,472	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,391,667	$ 125,496		$ 94,445	$ (31,051)	$ 357,472	1
2	Motor, Air Filters For A/C & Labor	2005	2,019		20	101	101	101	2
3	Repaired Hot Water Tank	2005	1,855		20	93	93	93	3
4	Repaired Compressor W/I Freezer	2005	2,855		20	143	143	143	4
5	Install New Laundry Tub	2005	2,100		20	105	105	105	5
6	Emergency Panels	2005	1,757		20	88	88	88	6
7									7
8									8
9									9
10									10
11									11
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,402,253	$ 125,496		$ 94,974	$ (30,522)	$ 358,002	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,402,253	$ 125,496		$ 94,974	$ (30,522)	$ 358,002	1
2									2
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4									4
5									5
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,402,253	$ 125,496		$ 94,974	$ (30,522)	$ 358,002	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 2,402,253	$ 125,496		$ 94,974	$ (30,522)	$ 358,002	1
2									2
3									3
4									4
5									5
6									6
7									7
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,402,253	$ 125,496		$ 94,974	$ (30,522)	$ 358,002	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 2,402,253	$ 125,496		$ 94,974	$ (30,522)	$ 358,002	1
2									2
3									3
4									4
5									5
6									6
7									7
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,402,253	$ 125,496		$ 94,974	$ (30,522)	$ 358,002	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 2,402,253	$ 125,496		$ 94,974	$ (30,522)	$ 358,002	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,402,253	$ 125,496		$ 94,974	$ (30,522)	$ 358,002	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 2,402,253	$ 125,496		$ 94,974	$ (30,522)	$ 358,002	1
2									2
3									3
4									4
5									5
6									6
7									7
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,402,253	$ 125,496		$ 94,974	$ (30,522)	$ 358,002	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 2,402,253	$ 125,496		$ 94,974	$ (30,522)	$ 358,002	1
2									2
3									3
4									4
5									5
6									6
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,402,253	$ 125,496		$ 94,974	$ (30,522)	$ 358,002	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 2,402,253	$ 125,496		$ 94,974	$ (30,522)	$ 358,002	1
2									2
3									3
4									4
5									5
6									6
7									7
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,402,253	$ 125,496		$ 94,974	$ (30,522)	$ 358,002	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Wheaton HC Properties		2005	1972	$ 1,496,317	$ 38,367	39	$ 38,367	$	$ 38,367	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Wheaton HC Properties			2005	51,761	2,588	20	2,588		2,588	10
11											11
12											12
13											13
14											14
15											15
16											16
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SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
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64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,548,078	$ 40,955		$ 40,955	$	$ 40,955	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	2201 Main LLC		2002	2002	$ 13,777	$ 353	40	$ 353	$	$ 1,163	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation - 2201 Main LLC			2002	11,381	569	20	569		1,992	9
10	Allocation - 2201 Main LLC			2003	13,412	671	20	671		1,676	10
11	Allocation - 2201 Main LLC			2005	666	15	20	15		15	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 39,236	$ 1,608		$ 1,608	$	$ 4,846	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 383,578	$ 15,047	$ 46,738	$ 31,691	10	$ 256,833	71
72	Current Year Purchases	346,333	33,406	33,872	466	10	33,872	72
73	Fully Depreciated Assets	37,344				10	37,344	73
74								74
75	TOTALS	$ 767,255	$ 48,453	$ 80,610	$ 32,157		$ 328,049	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		VAN	2003	$ 19,994	$	$ 3,569	$ 3,569	5	$ 11,667	76
77		Care Centers Allocation	1900	19,195	1,406	1,406		5	14,536	77
78										78
79										79
80	TOTALS			$ 39,189	$ 1,406	$ 4,975	$ 3,569		$ 26,203	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,046,875	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 175,355	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 180,559	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,204	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 712,254	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NWOS General Partnership. The facility exercised the option in 2005
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ 441,440			3
4	Additions							4
5	Allocated from Care Centers				6,552			5
6								6
7	TOTAL				$ 447,992 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: see note above *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO
16. Rental Amount for movable equipment: $ 3,085 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 10,293	$ 1,170		$ 11,463	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			25,766	372		26,138	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				67,591		67,591	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental					215	10,232		10,447	13
14	TOTAL			$		$ 36,274	$ 79,365		$ 115,639	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (96,950)	$ (76,775)	1
2	Cash-Patient Deposits	32,087	32,087	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	711,608	711,608	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	154,623	154,623	6
7	Other Prepaid Expenses	15,306	15,306	7
8	Accounts Receivable (owners or related parties)	307,500	1,535,969	8
9	Other(specify): See Attached Schedule	1,697,335	1,697,335	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,821,509	$ 4,070,153	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		828,181	13
14	Buildings, at Historical Cost		1,496,317	14
15	Leasehold Improvements, at Historical Cost	738,617	790,378	15
16	Equipment, at Historical Cost	438,314	769,586	16
17	Accumulated Depreciation (book methods)	(837,744)	(911,826)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		35,074	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	1,228,469	1,228,469	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,567,656	$ 4,236,179	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,389,165	$ 8,306,332	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 414,322	$ 414,322	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,125	27,125	28
29	Short-Term Notes Payable	1,635	1,635	29
30	Accrued Salaries Payable	78,301	78,301	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,676	3,676	31
32	Accrued Real Estate Taxes(Sch.IX-B)	55,967	55,967	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,228,469	1,228,469	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,809,495	$ 1,809,495	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		2,053,929	39
40	Mortgage Payable		1,793,654	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 3,847,583	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,809,495	$ 5,657,078	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,579,670	$ 2,649,254	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,389,165	$ 8,306,332	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,480,436	1
2	Restatements (describe):		2
3	Depreciation	(275,902)	3
4	Rounding	2	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,204,536	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	375,134	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 375,134	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,579,670	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,174,553	1
2	Discounts and Allowances for all Levels	(195,183)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,979,370	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	148,083	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 148,083	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	65,701	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16,156	19
20	Radiology and X-Ray	930	20
21	Other Medical Services	1,010	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 83,797	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	104,565	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 104,565	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	47,578	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 47,578	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,363,393	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,019,723	31
32	Health Care	1,840,174	32
33	General Administration	1,137,243	33
	B. Capital Expense		
34	Ownership	808,135	34
	C. Ancillary Expense		
35	Special Cost Centers	115,639	35
36	Provider Participation Fee	67,345	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,988,259	40
41	**Income before Income Taxes (line 30 minus line 40)****	375,134	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 375,134	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Not Complete **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,929	2,354	$ 63,306	$ 26.89	1
2	Assistant Director of Nursing	2,387	2,589	73,867	28.53	2
3	Registered Nurses	9,647	10,808	293,542	27.16	3
4	Licensed Practical Nurses	15,530	17,055	423,396	24.83	4
5	CNAs & Orderlies	48,364	51,532	628,730	12.20	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,566	1,777	23,715	13.35	8
9	Activity Director	2,048	2,268	26,183	11.54	9
10	Activity Assistants	5,510	5,673	49,524	8.73	10
11	Social Service Workers	9,496	10,634	150,325	14.14	11
12	Dietician					12
13	Food Service Supervisor	1,951	2,198	35,500	16.15	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,390	21,072	183,360	8.70	15
16	Dishwashers					16
17	Maintenance Workers	2,766	3,027	40,422	13.35	17
18	Housekeepers	18,785	19,903	161,954	8.14	18
19	Laundry	2,705	2,940	25,364	8.63	19
20	Administrator	2,366	2,526	95,138	37.66	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,993	7,653	83,996	10.98	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,495	1,719	18,581	10.81	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	152,928	165,728	$ 2,376,903 *	$ 14.34	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	181	$ 8,326	01-03	35
36	Medical Director	Monthly	1,100	09-03	36
37	Medical Records Consultant	Monthly	4,472	10-03	37
38	Nurse Consultant	Monthly	250	10-03	38
39	Pharmacist Consultant	Monthly	1,909	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	64	3,136	11-03	44
45	Social Service Consultant	9	520	12-03	45
46	Other(specify) Therapy Conslt.	1	24	10A-3	46
47	Care Plan Coordinator CCI	Monthly	4,959	10-03	47
48	Dietary Consultant - CCI	Monthly	4,490	01-03	48
49	TOTAL (lines 35 - 48)	255	$ 29,186		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	444	$ 16,482	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	444	$ 16,482		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Todd Tedrow	Administrator		$ 30,594
Ken M. Bogard	Administrator		64,544
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 95,138

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR & R	Accounting	$ 18,000
Care Centers, Inc.	Accounting	15,000
Personnel Planners	Unempoyment Consultant	1,039
Care Centers, Inc.	Bookkeeping	25,092
Care Centers, Inc.	Home Office Expense	103,320
Care Centers, Inc.	Ancillary Admin. Serv.	14,760
Care Centers, Inc.	Data Processing	3,690
ADP, Inc.	Payroll Services	4,446
Care Centers, Inc.	Computer Services	738
Achieve Health Care A/R Software	Computer Services	10,213
ADP Clocks	Computer Services	3,077
See Supplemetal Schedule		85,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 284,375

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 51,653
Unemployment Compensation Insurance	26,005
FICA Taxes	180,165
Employee Health Insurance	59,687
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	541
Other Employee Wellfare	3,324
Holiday Expense	1,696
TOTAL (agree to Schedule V, line 22, col.8)	$ 323,071

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,435
Advertising: Employee Recruitment	22,736
Health Care Worker Background Check	1,564
(Indicate # of checks performed 71)	
ICLTC	6,319
Dues & Subscribtions	1,214
Licenses & Fees	1,706
Yellow Page Advertising	46
Alloc. From Care Centers	3,613
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(46)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 38,587

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,536
Educational Expense	831
Alloc. From Care Centers	3,559
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,926

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Wheaton Care Center # 0039115 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Wheaton Care Center # 0039115 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC - $6,750**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,528** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **67,345**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.